# MENTAL DISTRESS OF WOMEN IN SOUTHWEST UGANDA: EXPRESSION AND MEASURE

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# ABSTRACT

Michael Fischer: Mental Distress of Women in Southwest Uganda: Expression and Measure
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Background: Anxiety and mood disorders are common around the globe and the cause of significant morbidity for all the world's populations. Case finding of mental disorders is challenging since screening instruments, to be accurate, must be valid in the particular setting in which they are being applied Diagnosis in primary care clinics can also be challenging since patients usually present with a wide variety of problems that can be difficult to interpret. Our objective was to screen women for anxiety and depression in one district of southwest Uganda and to investigate their complaints and illness concepts. A second objective was to describe their idioms of distress, especially how their social circumstances relate to their illness. We chose to focus on women age 18-35 as a sample of convenience in our exploratory study.

Methods: We screened for anxiety and depression 115 women chosen by convenience sampling at three sites providing services for women in the Kisoro district using the SRQ-20 Yes-No Questionnaire.Those who met criteria were immediately interviewed in the local language by a female Ugandan team member using Kleinman's Eight Questions in order to elicit their explanatory model of illness.

Results: Very few participants had more than a primary school education, most were married and only a few received income from employment outside the home. Depression was common in women at all three study sites, but was particularly prevalent among participants recruited at a women's center located in an area that was geographically remote. These women were older than their counterparts at the other two sites, living in larger households with more children to care for. They were statistically more likely to endorse cognitive, and decreased energy domains of depression on the SRQ 20 compared with their counterparts at a clinic for mothers and babies. They were not more likely to endorse somatic or affective symptoms or depressive thoughts.,

In the Kleinman interview, all 87 of the participants with depression (100 %) used somatic symptoms to describe their illness. The average number of somatic symptoms offered was 3.9. 32 % reported five or more somatic symptoms. 29 % reported one psychiatric symptom and 1 % (one participant) reported 2 psychiatric symptoms. 84% considered their illness to be moderately or very severe and 80 % feared that it would result in premature death or disability. 67 % said that their physical health had declined as a result of their illness and 39 % reported that they were not keeping up with their daily activities as a result of their problem. Marital problems (53%), and being overworked (46 %), as well as other environmental factors such as not enough food (24%), reproductive health concerns (22 %) and poverty (15%) were the most common causes of illness offered by participants. 22% suggested that the cause was in some way related to mental health, and 11% said that it was due to witchcraft. 36 % responded "do not know" to the question about cause. Expectations regarding

illness treatment for 76% were for x-ray or medication and, for 83 %, to feel better. Sample narratives from the Kleinman interviews illuminate symptom meanings. In their idioms of distress are heard echoes of their economic and marital problems.

Conclusion:. The somatic and affective symptoms and depressed thoughts sub-scales of the SRQ-20 screening instrument may not differentiate as well for depression compared with cognitive impairment and decreased energy sub-scales in this milieu. At the same time, women with depression in southwest Uganda complain primarily of somatic symptoms, and therefore it is important to train health providers to look beyond these symptoms for evidence of cognitive problems and decreased energy. The somatic idiom may be how women in southwest Uganda express every day levels of distress or social concern. Having depressive thoughts, however, especially feelings of uselessness and hopelessness, is not how mild depression manifests itself in this population.

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# LIST OF ABBREVATIONS

AIDS Acquired Immunodeficiency Syndrome

APRN Advanced Practice Nurse Practitioner

CMD Common Mental Disorder

CNC Clare Nsenga Clinic

DSM Diagnostic and Statistical Manual of Mental Disorders

EM Explanatory model

HIV Human Immunodeficiency Virus

IRB Institutional Review Board

KYB Kyibumba Young Women Community Based Development Initiative

OECD Organization for Economic Co-operation and Development

PHC Primary health clinic(s)

PHC at MH Primary Health Clinic at Mutolere Hospital

PTSD Post Traumatic Stress Disorder

SRQ-Self-Reporting Questionnaire

SSA Sub-Saharan Africa

STD Sexually Transmitted Disease

UNC -CH University of North Carolina-Chapel Hill

WHO World Health Organization

# GLOSSARY OF TERMS

| | |
|---|---|
| African Diaspora | The mass dispersion of peoples from Western and Central Africa to different regions throughout the Americas and the Caribbean as a result of the transatlantic slave trades of the 1500s to the 1800s. |
| Causal Model | Aspect of the explanatory model schema relating to the cause of the problem |
| Common Mental | A term used by the WHO usually involving anxiety, mild depression, post- traumatic stress disorder and drug use disorder |
| Explanatory Models | An approach of medical anthropology that views idioms of distress as the result of a schema for understanding the label, cause, course, consequence, treatment and outcome or impact of problems (Kirmayer, Dao & Smith, 1998, p. 14). |
| Idioms of Distress | Culturally meaningful distress syndromes |
| Kleinman's Eight Questions | An interview guide for eliciting the patient's explanatory model invented by Arthur Kleinman |
| Somatic Symptoms | Symptoms experienced in the body |
| Somatic Idiom | Culturally meaningful distress syndromes experienced and expressed in terms of symptoms experienced in the body |

## BACKGROUND

Common mental disorder (CMD) is a term defined by the WHO most commonly referring to mood, anxiety, and drug use disorders. In a recent meta-analysis of global epidemiologic studies, Steel et al. (2014) found that, world-wide, 17.6 % of respondents were identified as meeting criteria for a CMD during the 12-months period of time preceding assessment, and 29.2 % of respondents were identified as having experienced a CMD at some time during their lifetimes (p. 476). The numbers from Sub-Saharan Africa (SSA) were somewhat lower than the global averages, 10.8 % and 22.0 % (p. 483).).

As noted by Seedat et al. (2009), epidemiologic surveys have consistently documented a pattern of higher rates of anxiety and mood disorders among women than men and higher rates of drug use disorders among men. The gender roles hypothesis has been put forward to explain this difference, and the hypothesis asserts that the differences are due to differences in the stressors, coping resources and opportunities for expressing psychological distress available differently to women and men. (p. 785). The socially and culturally assigned gender based roles and responsibilities, the vastly different life experiences of men and women, and the multiple roles played by women including child-bearing, running the family home and, earning income (Patel, 1999, p.1466) likely has led to considerable stress on women thus increasing their vulnerability to CMD.

In addition, these prevalence numbers are likely to be inaccurate because the way in which a mental health condition may be expressed varies by cultural context, and the surveys used to detect mental illness are not always adapted, particularly within non-European settings, to take these differences into account (Steel et al., 2014, p. 488). In these settings, somatic complaints are often the most common presentations of minor psychiatric disorders such as anxiety and mild depression. Many patients with anxiety disorders attribute their symptoms to hypertension or heart disease initially, and stress and depression are often not recognized as health related problems at all, but rather as life problems. For example, in Zambia, problems of affect, such as low self –esteem, unhappiness or thoughts of suicide, were seen by women in one community based study in Lusaka (Aidoo & Harpham, 2001) as problems of the mind, but not necessarily as ill health. For this group, mental health implied 'madness', and this attitude, which reflects the stigma that is associated with mental health issues, inhibited the women from seeking psychiatric services (p. 210). In SSA and regions of the world such as the Caribbean basin that bear the influence of the African diaspora, mental health problems are sometimes seen as the work of evil spirits. (Proceedings, 2002),

In these settings, therefore, traditional Western descriptors of mental distress are not valid, and a different idiom is needed."Idioms of distress" were referred to by their inventor, Mark Nichter (1981), as alternative, culturally salient modes of expressing distress, as cited in Hinton & Lewis-Fernandez (2010). Nichter, a sociocultural anthropologist specializing in medical anthropology was one of the first researchers to explore how psychosocial distress is communicated in various cultures often by symptoms experienced in the body. As an example of a somatic cultural distress idiom, Nichter (1981)

says of South Kanarese Havik Brahmin women in South India, "[t]o say that she has lost weight is an indication that she appears to be down as a person as well as in weight and strength" (p. 383). He describes these women as having, in their social milieu, "limited opportunities of expressing psychosocial distress" (p. 379), and his paper elucidates how adoption of a distress idiom for these women may be a healthy "adaptive response" to a "pathological situation" in a way that is "culturally meaningful" (p. 402) Culture, was said by the historian Edward Shorter, to influence symptom expression in a such a way as to allow only the most socially correct behaviors to be exhibited (as cited in Bagayogo, Interian & Escobar, 2013, p. 65).The so-called somatic idiom, seems to have evolved as the socially correct way for psychological distress to be encoded and transmitted. Various such somatic idioms and their use by women especially in low and middle-income countries (LMICs) have been documented (Patel, 1999). In summary, representations of mental health depend on both culture and gender issues, and there is therefore the need for locally situated models to understand the manifestation of mental illness in a particular setting.

## MENTAL ILLNESS IN UGANDA

Uganda is typical of other low resource countries in under-reporting and under-treatment of mental health issues. According to the OECD's 2014 Social Institutions and Gender Index (SIGI), attitudes that justify practices such as girl's early marriage, a husband's beating his wife for specific reasons, denying a woman the right to decide about whether or not to use contraception, denying a woman the right to refuse sex with her husband, and declaring that household and caring tasks should be performed by girls but not boys, prevail in Uganda, especially in southwest Uganda. Domestic violence and gender inequality are among the factors that have been shown to be social determinants of depression (Patel, et al, 2010). As elsewhere, mental illness is stigmatized in Uganda, and is therefore likely to be under-reported.

At the same time, the health system is not equipped to address issues of mental health. There are very few trained mental health workers in Uganda (WHO, 2006, p.7), and general caregivers there are said to be so overburdened by acute conditions such as infectious diseases that they do not as much pay attention to underlying emotional problems which also contributes to low detection rates of the condition. (Okello & Neema, 2007). General medical practitioners may also not be receiving the training necessary to recognize patients with these conditions (WHO, 2006). Furthermore, in Uganda, the public is said to lack awareness that mental ill health is a medical condition just like any other problem that can be treated. ("Proceedings", 2002) Since many patients view only the physical symptoms to be signs of ill health, the patients themselves may self- diagnose and self-medicate and therefore not ever access the health system (Aidoo & Harpham, 2001, p.211).

Attitudes of health workers are also a factor. Some general health workers were found to be of the opinion that it was not their responsibility as health workers to manage mental health conditions (Kigozi, 2016, p. S42). Furthermore, many were said to find recognizing and managing depression to be quite challenging as the patient's in primary care clinics often present with somatic symptoms which may be more difficult to identify as signs of depression (Kigozi, 2016, p. S42).

This paper describes an exploratory study to assess the mental health of women in the community and in primary care clinics in Uganda, specifically to better understand the meaning of the somatic symptoms that they present to their caregivers This is important because patients with psychosomatic symptoms of mental illness require a different treatment approach than those with the same symptoms that arise from an untreated medical illness. Furthermore, those in whom the somatic idiom may be adaptive and non-pathological need to be sorted out from patients in whom psychosomatic symptoms are a feature of a more serious depressive disorder that requires psychiatric treatment. This line of inquiry is needed to guide caregivers in primary care clinics in Uganda who have indicated that they are struggling with these issues and need better guidance.

## STUDY DESCRIPTION

### Objective:

*The setting*: (Map provided in Appendix 5) This study was entered into as part of an ongoing cooperative partnership between the Mutolere Hospital district hospital in Kisoro, Uganda in the rural southwest of Uganda, near the border with Rwanda. and the University of Connecticut School of Medicine. The inhabitants of this temperate and lush equatorial region subsist mostly on small plot farming, The study focused on women between 18-35 years since it is plausible that mental health issues are particularly relevant to this age group because these are the years when women have multiple stressors in their lives. The study was conducted over a nine day period in July of 2014 in three settings: a post-natal clinic at the district hospital in the town of Kisoro, (Public Health Clinic at Mutolere Hospital), a primary care clinic outside of town (Clare Nsenga clinic), and in and around a women's center in the rural outskirts (Kyibumba Young Women Community Based Development Initiative). The locations were chosen to capture a demographically varied range of women all seeking some form of care in their community.

*The sample:* We used a non-probability convenience sample.Young women who looked to be in the target age range of 18 to 35 were approached by a Ugandan female study team member. Women under 18 and over 35 years of age were not included. Potential recruits were read a prepared script (Appendix 3) in the local language of Rufumbira, and those who were found to be eligible, and who agreed to participate, were enrolled. There were no other criteria for enrollment. The total sample size was 115.

## Methods:

*The study design*: Following the collection of basic demographic and other descriptive data, each study participant's mental health status was measured using the Self-Reporting Questionnaire, (SRQ-20), a 20 items Yes-No WHO research instrument developed using psychiatric morbidity instruments from a wide variety of cultural backgrounds to screen for mental disorders in the community (Abbo, Ekblad, Waako, Okello & Musisi, 2009), and slightly modified for use in SSA by Aidoo & Harpham (2010) (see Appendix 4). Each of the items on the SRQ-20 is scored 0 or 1. A score of 1 indicates that the symptom was present during the past month, a score of 0 indicates that the symptom was absent. The maximum score is therefore 20. Seven or higher is the cut-off point for a diagnosis of CMD used by Aidoo & Harpham (2010), but other authors now advocate the use of a different cut-off point. Scholte et al. (2011) found that the SRQ-20 performed most reliably as a predictor of common mental disorder (CMD) in women, in a Rwandan community setting, when the cut-off point was set at 10. In this study, the SRQ 20 results are reported using both the 7 or higher, and the 10 or higher cut-off points, but the cut -off point for participants to proceed to the interview phase in our study was 7 or higher.

Tafari, Aboud & Larson (1991), working with the SRQ-20 to screen for mental illness in a rural Ethiopian adult population, found three meaningful factors, "interference with intellectual and work functioning, emotionality and somatic expression" (p. 201) corresponding to the three "cognitive" items which are not thinking clearly (8), difficulty with decision making (12)and work suffering (13); the four anxiety and depression affective items which are crying more than normal (10), being unhappy (9), being frightened easily (4) and

feeling worthless (16); the four "somatic" symptom items which are headache(1) lack of appetite (2), poor digestion (7), and sleeping problems (3). To this category, in the analysis of this study's data was added having uncomfortable feelings in stomach (19).In addition, three "decreased energy" items which involve being easily tired (20), always feeling tired (18), , not enjoying activities (11); and four "depressive thoughts" items which are , being unable to play a useful part in life(14) , thinking of ending life (17) having lost interest in things (15 ) and being nervous, tense and worried (6). Hands shake (5), an alcohol use disorder item, was not included in this analysis.

The SRQ was administered in the local language of Rufumbira by a two -person study team consisting of a female Ugandan trained social worker and a US trained female Advanced Practice Nurse Practitioner (APRN). Participants who had scored of 7 or higher on the SRQ 20 were asked to agree to submit for interview immediately following the administration of the survey. The interview consisted of the set of eight questions developed by Arthur Kleinman and modified for use in SSA by Aidoo & Harpham (2001). Arthur Kleinman is an American psychiatrist who is a leading expert in the field of transcultural psychiatry. Kleinman (1980) coined the term "explanatory model" to characterize held concepts about illness of patients and their caregivers, specifically, questions such as "what name does your illness have?, "how does it work?", "what are the causes of it ?"(ie. what is the "causal model"?), "what impact does it have?", "what is most feared about it?", and "what should be done about it?" Kleinman's Eight Questions (see Appendix 4) have become established as a research tool for understanding underlying meanings which is especially important when it comes to the treatment of patients with

mental illness in various contexts, since the expression and articulation of symptoms vary so widely from one setting to another.

The interview was conducted in Rufumbura by the Ugandan social worker. Privacy was assured by conducting all interviews in a room behind a closed door when available, or in a cubicle set apart from others when the interview was conducted in a large waiting area. Responses were recorded in English by hand by the APRN according to the translation from the Rufumbira provided by the Ugandan social worker and assembled into a study package. Patient narrations were in the third person, the interviewer's recounting of the participants words. Study materials were kept in a secure location at all times and analyzed some months later by the investigators in the US. The primary purpose of the in-depth interview was to investigate the explanatory model for the presenting symptoms, primarily around the topics of held concepts regarding causation of illness, impact of illness, and expectations of treatment of women with CMD in this setting. While the primary purpose of the Kleinman interview was to elucidate explanatory models, it also served as a tool to determine the distress idioms reported on in this study.

*Ethics Approval:* Ethical approval for the study was obtained from St Francis Mutolere Hospital in Kisoro, Uganda and the IRB at UNC-CH. Once recruited, enrollees first participated in an informed consent process in which they were read a version of the informed consent document that had been translated into Rufumbira by our Ugandan study member which stressed that participants should expect to receive no treatment or other personal benefit as a result of their participation in the study and that their

participation was voluntary, and that no information identifying the participants by name or in any other way would appear in the report.

# RESULTS

*Characteristics of study participants*

Table 1 presents some summary characteristics of the study participants. Ages for the 115 study participants were distributed evenly across the desired age range. Of the 115, seventeen participants had a secondary school education and four had a university education. Thirty-eight were married and fifty-five had a long-term partner, combined in the table under "married". Over half of the women had three or fewer children. Seven had more than six children. Twenty-one of the women had a husband or partner who was working full time, and fifteen lived in a household with eight or more members. Therefore, even though the sample was purposive, we have achieved a fair degree of diversity among the participants.

The three study locations provided very different services. The women at the Public Health Clinic at the Mutolere hospital were there for a post partum check with their baby. Their lives were organized enough to make it in to town on the day of their participation in the study for a preventive health care visit. By contrast, many of the women who participated in the study at the KYB women's center were members of the community who just happened to be passing by, and who agreed to participate. Despite these differences overall no statistical difference was found among most of the background and demographics among the three locations. On age, there is a significant difference at 95% confidence in the ages of the participants between PHC and KYB with KYB population being the older of the two by about 3 years in the average. On household size, there is a statistically significant difference between PHC at MH and KYB (p-value =0.0043) The KYB population has

the larger household size. On number of children there is a difference, approaching significance, between CNC and KYB. (p=0.0626). Women who participated in the study from KYB had more children and larger households, both of which can be explained by the age difference.

Table 1 Description of study population by site (n=115)

| | CNC | PHC at MH | KYB |
|---|---|---|---|
| N* | 11 | 56 | 48 |
| Average age | 26.18 +/-5.21 | 24.95 +/- 4.65 | 27.70 +/- 5.34 (N=47) |
| Percent married | 0.727 | 0.872 | 0.745 |
| Percent primary school or less | 0.917 | 0.764 | 0.854 |
| Percent employed outside the home | 0.100 | 0.089 | 0.100 |
| Percent partner employed | 0.500 | 0.347 | 0.231 |
| Average number of children | 1.72 +/- 1.49 | 2.38 +/-1.79 | 3.23 +/-2.26 |
| Percent household size greater than 5 | 0.273 | 0.286 | 0.566 |

*missing data points reduce the N in some calculations

Analysis of the average number of "yes" answers by site, and of the percent of respondents who said "yes" on 7 and 10 items of the SRQ 20 Questionnaire is shown in Table 2. There are some significant differences between the sites. On average number of items with "Yes" answers, there is a statistically significant difference between PHC at MH and KYB (p=0.0009), with the women at KYB giving more "yes" answers.. On the percent of respondents who said yes" on 7 items, there is also a statistically significant difference between PHC at MH and KYB

(p=0.0001). KYB had the higher percent of respondents who said "yes." On percent of respondents who said yes" on 7 items, there is also a statistically significant difference between CNC and KYB (p=0.0049). KYB had the higher percent of respondents who said "yes." On percent of respondents who said yes" on 10 items, there is also a statistically significant difference between PHC at MH and KYB (p=0.0016). KYB had the higher percent of respondents who said "yes." On percent of respondents who said yes" on 10 items, there was no difference between CNC and KYB. The rank order from fewest to most on "yes" answers to items on the SRQ-20 depression scoring instrument is PHC at MH to CNC to KYB. From this data and from what is known about the sites from Table 1, it is possible to speculate that women in the more rural site had greater family burdens since they were older, had fewer resources and were more likely to respond positively to the depression related items on the SRQ-20.

Table 2 Average number of items with "Yes" answers and percent of respondents who said "Yes" on 7-items and percent of respondents who said "Yes" on 10-items by site

| Site | | Average number of items with "Yes" answer | Percent of respondents who said "Yes" on 7 items | Percent of respondents who said "Yes" on 10 items |
|---|---|---|---|---|
| | | | | |
| CNC | 11 | 9.18 | 0.636 | 0.545 |
| PHC at MH | 56 | 8.68 | 0.618 | 0.473 |
| KYB | 48 | 12.27 | 0.939 | 0.776 |

The average percent of respondents answering "Yes" on each of the five SRQ-20 sub score domains by site is shown in Table 3. Results show that there is a statistically significant difference between the PHC and the KYB women's center on the percentage of women who indicated cognitive impairment and decreased energy, though there was no difference between the sites between the percentage of women indicating affective or somatic symptoms or depressive thoughts. Once again, it is only possible to speculate that the women who come to the KYB are depressed in more profound ways than those in the other sites, with the depression symptoms manifesting themselves across a broad range of impairments, even if they primarily present with somatic symptoms. That there is no statistically significant difference between PHC and KYB women's center on the percentage of women indicating somatic symptoms, makes case mix, a difference in the proportion of women with medical illness vs. depression at the two sites, less likely to be the cause of the observed differences between them, if one accepts the premise that a higher percentage of women with medical illness would be expected to report somatic symptoms compared with women with depression. On the other hand, it is possible that all participants answered "yes" for somatic conditions because they had come to seek some form or care, irrespective of whether they were depressed or not. So it could be the case that some of the women at the PHC are being seen for medical illness, and are not cases of depression according to the 7 or 10 item cutoff. A greater number of the women at the KYB are more likely to be depressed.

Table 3

Percent of respondents answering, "Yes", for each SRQ-20 sub-score domain for each site

| | N | Cognitive | Affective | Somatic | Decreased energy | Depressive thoughts |
|---|---|---|---|---|---|---|
| CNC | 11 | 0.515 | 0.364 | 0.659 | 0.394 | 0.500 |
| PHC at MH | 55 | 0.448 | 0.377 | 0.545 | 0.461 | 0.395 |
| KYB | 49 | 0.789 | 0.556 | 0.638 | 0.660 | 0.505 |

Of the four items that make up the depressive thoughts sub- score domain, across all sites, the average percent of respondents answering "Yes" on the items, "lost interest in things" (15), and feeling nervous, tense or worried (6) are not low when compared with average percent of respondents answering "Yes" on other SRQ-20 items. They are in the same range as average percent of respondents answering "Yes" on other SRQ-20 items. The average percent of respondents answering "Yes" to "thinking of ending life" (17), on the other hand, stands out as being very low, and the average percent of respondents answering "Yes" to "unable to play useful part in life" (14) is also low compared with the range of average percent of respondents answering "Yes" on other SRQ-20 items. This lends credence to the hypothesis that most Ugandan women reject affective terms such as hopelessness and uselessness when referring to their mental condition instead thinking of their mental condition more in terms of how they physically feel, and what they can and cannot do. This is also borne out by the interviews results, which are now described.

## *Analysis of Interview Data:*

The explanatory model approach of medical anthropology tends to view idioms of distress as the result of a schema for understanding the label, cause, course, consequence, treatment and outcome or impact of problems (Kleinman (1981) as cited in Kirmayer et al., 1998, (p.14). The data from this study falls under the label (symptoms), cause and impact categories of the explanatory model schema. This data, based on the 87 participant responses to the Eight Kleinman Questions, is presented as reported illness symptoms (idiom of distress and illness phenomenology), illness causation (causal model), and impact of illness and expectations of treatment.(Tables 4-6). Sample narratives are included in each of the three tables in order to illuminate category meanings. The number of participants in each category is also reported in the tables.

### a) Idioms of distress:

### These are based on data gathered from Kleinman interview Question 1. "What do you call your problem? " "What name does it have?"

Symptoms reported by the participants (n=87) in the interview phase of the study are shown in Table 4. Of the non-specific physical complaints, the commonest reported were aches and pains: headache, back pain, joint pain, body aches, limbs feel paralyzed. Next most common (numbers listed in table) were a variety of gastro-intestinal complaints including weight loss and poor appetite. The majority were stomach ulcers and stomach pain, often offered in the context of not getting enough to eat, or not having enough time to eat during the course of the busy day. The next most common categories of symptoms were weakness or decreased energy, difficulty sleeping, a variety of gynecologic symptoms, heart symptoms, mostly palpitations, dizziness, insects crawling on skin, itchy skin and miscellaneous respiratory symptoms, including increased spitting and throat

pain. Of those who reported about a specific disease, parasites were the most common, followed by HIV, seizure disorder and urologic.

Of the psychiatric complaints, increased stress was the most common, followed by the idiom of chronic unease, "being without peace". There were miscellaneous complaints of "thinking too much", "lack appetite for husband", "hates herself", "tears flow", "not thinking clearly", "depressed", "people talking about her big stomach".

As is evident from Table 4, the number of somatic complaints vastly outnumber the number of psychiatric complaints offered Most women expressed their distress in a somatic idiom. This was true even when the underlying problem was recognized by the respondent to have an emotional component, or be related to a stressful life problem. Symptoms of stress and anxiety are often attributed to the heart or chest. Aches and pains are associated with backbreaking work in the fields, or with fetching water. Headache can be associated with life problems or "too many thoughts". Stomach ulcers, a frequent complaint, are often associated in the narratives with not having enough time to eat due to heavy workload or with not having enough to eat.

Table 4 Idioms of distress of participants with depression

| *Illness symptoms* | Number Reporting | Sample Narratives |
|---|---|---|
| Specific physical illness alluded to | 16 | Stressed by harassment she receives from her late husband's family, she contracted HIV from her husband; loss of appetite, loss of energy. |
| Somatic complaints | | |
| *Aches and pains* | 68 | Headaches from too much hair on head and no money to go to barber. |
| *Gastro-intestinal distress* | 67 | Too much gas since childhood, maybe from worms, being worried all the time that people might talk about her because of her big stomach. |
| *Weakness and tiredness* | 57 | Has a sleeping sickness, feels sleepy, and lacks appetite for her husband. |
| *Weight loss* | 34 | Stomach ulcers from not having what to eat; at times can have [food] for the children only. |
| *Dizziness* | 13 | Family planning injections given every three months causing dizziness. |
| *Heart* | 12 | Quarreled with husband, heart rotates a lot, fears it will come out. |

| | | |
|---|---|---|
| Psychiatric symptoms | | |
| *Not being at peace* | 25 | The husband contributed to the death of her father in law and his death may have contributed to her *not being at peace with her husband.* At one time he threatened to kill her also. |
| Behavioral symptoms | | |
| *Lack of appetite* | 23 | Decreased feelings for husband, fears that husband will leave her because she does not have feelings for her husband, he will look for other women; she hates herself, not worthy of being with others, stressed, needs medication to improve her appetite, tried eating fruits, did not help, |
| *Lack of sleep* | 12 | She loses sleep because of so many thoughts in her head. |

## b) *Causal models*:

Causal models are based on responses to Kleinman interview Questions 2. "What do you think has caused your problem?" and Question 3. "Why do you think it started when it did? Results are shown in Table 5.

A majority of women reported that their problem was with their husband: He does not help, husband beats her, says has negative feelings towards husband, husband drinks, husband does not give money, says problems began after marriage, rival women.

Nearly half of the women reported excessive workload to be the problem. Included in this are, work is too hard, or too physical, and does not eat on time due to work, or has no time or energy to eat or care for self, house or children. Environmental causes that were given were poverty, and

a separate category reflecting the harshness of life, which includes inadequate housing, lack of food or bad food, and bad drinking water.

Women attributed their health problems to a range of other causes. Persistent difficulties from complications of childbirth, and complaints about side effects as a result of family planning injections or procedures were common. Some women believed in witchcraft and saw it as the cause. Other causes mentioned were being bewitched, in some cases by neighbors; neighbors, jealous about their relative tranquility or prosperity, was another theme. Of the causes for psychiatric symptoms, stress and "lack of peace" were the most common, and the remaining miscellaneous causes included statements of psychiatric illness such a "hates herself" and " not worthy of others". "Do not know" was the third most common response of women to the question about cause.

Table 5 Causal explanations of mental distress

| Categories | Number reporting | Sample Narratives |
|---|---|---|
| Marital problem | 46 | Husband does not care about the family and the home. He is not creative and he is not working. He drinks a lot and because of his alcohol drinking he refuses to work to give her money to buy food and basic necessities. She has no house, no bed and no blankets. She would like an opportunity to work so that she can at least look after the family. |
| Overwork | 40 | She miscarried because she was doing a lot of work and carrying baby on her back with a wrap around the abdomen. |
| Do not know | 31 | Does not know what the problem is, only knows that the treatment is not working. |
| Environmental causes | 21 | She fears that heavy lifting has caused polio, cannot work in the garden digging. |

| | | |
|---|---|---|
| Mental health problem | 19 | Low self -esteem, hates herself; cannot feed on the right breast, cannot do all her work when she is pregnant as other women seem able to do, husband hates her because of her illness, he does not take care of her. |
| Poverty | 13 | Husband does not give care; she has been depressed since she got married over 15 years ago; if there is a medicine that cures poverty, she will get healed and have peace because poverty is the main cause. |
| Difficult child birth | 12 | When they pushed some machines through her vagina checking her uterus, it might have caused her to have pain because before, she had no pain. She thinks they might have bewitched her. |
| Witchcraft | 10 | Had a severe mental health problem, lasting 1 and 1/2 year, she went to a local doctor who healed her; was bewitched but does not know why. Dropped out of school, parents paid for her to have the spell to be taken off her, and now cannot afford to pay for her school. |
| Family planning | 7 | She thinks its family planning that has caused her pain. She fears being operated on and also getting other diseases like cervical cancer and she fears giving birth again, and she fears to be in the public, thinking they will talk about her. |

## c) Impact and course of illness:

### These are based on data gathered from participant responses to Kleinman interview Questions 4 through 8

Common fears and worries of our participants were: dying prematurely, having cancer, cannot do daily activities due to physical problems, their own health, will become useless; worries about

HIV/STDs; children suffering or being orphaned, or worries about health of children, or that cannot care for children. Also, husbands infidelity, cannot conceive, will miscarry (Table 6).

As far as expectations of treatment is concerned, the majority hoped for or expected a cure or wanted to feel better, wanted an x ray or medicine or both, did not know what treatment was wanted, wanted a general exam of the body, wanted to find out what the real cause of the problem was, wanted an opportunity to work. What comes through loud and clear from this data is that women are suffering and looking for help.

Table 6: Impact and course of illness

| | Number reporting | Sample Narratives |
|---|---|---|
| *Fears that problems will result in disability or death* | 70 | Fears that headaches will bring dizziness when she is alone and she will fall down get hurt and die; fears that the stomach pain will bring cancer. |
| *Fears that children will be orphaned or not well cared for* | 17 | Has HIV, from husband who worked in Kampala and was with other women; fears that she will be bed ridden and no one will help her, and her children will suffer. |
| *Worries about husband's extra-marital habits* | 4 | |
| *Fears sterility* | 6 | Has not been able to conceive since her first child, fears that she is sterile; wants x ray so she can find out what is wrong and medicine so she can conceive and feel better. |
| *Work affected due to problem* | 34 | Fears that when she is carrying something heavy her back will crack and break. |

| | | |
|---|---|---|
| *Family affected due to problem* | 10 | When she argues with husband, she gets headaches; when she asks husband for her and her children's clothes and necessities he starts to quarrel and says he does not have money. If headache continues, she fears that she will have a mental illness. Thinks about leaving her partner, getting an opportunity to work. If she can work, she can take care of the family and she won't have to think about leaving her partner. |
| *Opportunity to work* | 3 | |
| Emotions affected due to problem | 13 | Has bad dreams, is being chased, sleepless nights, her brother used to beat her with a stick, quarreled over access to parent's land and harvest, he threatens to kill her, she is unable to think clearly, requests x ray to diagnose what is wrong with her brain.<br>Fear causes her to have trouble breathing, fear of getting beaten by her family, fears that boys can rape her when walking alone on the road; wants medicine for fear, hopes that her heart will relax and she can be comfortable.<br>Because she is losing the weight, she can have other problems and she will die. |
| Physical health affected due to problem | 55 | |
| *Treatment expectations* | | |
| Investigations and/or medications | 66 | Thinks medicine may bring change in her life and she becomes again strong.<br>Lower abdominal pain. When she goes to the hospital, she is given medicine for ulcers and she feels better for a while.<br>Stress has caused all the diseases that she is suffering from: nausea, gas, backache, lack of energy, paralysis. Still she wants an x-ray to find out what is really wrong with her. |
| To get better | 72 | Stomach ulcers, not eating on time, started when she got married, lot of work and no time to eat, she will receive any kind of medicine that is given to her as long as it works. |

| | | |
|---|---|---|
| | | Urinary incontinence following a bicycle accident over 10 years ago, soils her clothes does not go out much and fears that if she gets married, the husband will reject her. She has given up and has lost hope. She has been to the hospital in Kampala but treatment with medicine did not work (age 24) |

## LIMITATIONS

On the day of their participation in this study, some women were at a clinic for medical care, some were at a clinic for mothers and their babies, and others just happened to be at or in the vicinity of a women's center, and agreed to participate. Some women had significant medical conditions such as HIV or a serious neurologic condition. The symptoms reported to study personnel by these participants with known chronic and serious medical conditions were by no means purely psychological. Nor were the symptoms of the other participants likely all psychological either. The participants in this study were not seen as patients or with their regular caregivers. So a drawback of the study is that there is some uncertainty as to which of the reported symptoms were primarily physical, and which symptoms were primarily psychological. No participant in this study was acutely ill. Many participants reported to study personnel that they had been treated for their symptoms, and that they were not feeling better. What seems likely is that many of the women suffered with real symptoms from chronic conditions related to the environment such as intestinal parasites and stomach problems, from drinking bad water and not having enough nutritious food to eat, and from overuse symptoms like backache or headache that are as a result of the accumulated physical stress on the body of performing, on a regular basis, such activities as digging in the soil with a hoe, or carrying heavy loads on the head. Many of the women reported having already been treated medically for parasites and stomach ulcers, for example, and that they were not getting better. Still, it is certainly still possible that many of them had received inadequate medical treatment.

What is also known is that non-specific somatic complaints that are chronic can be a feature of depression, and while very real to the sufferer, non-specific complaints such as

abdominal pain, headaches and backache may best be treated not with x-rays and medications, but with attention to underlying psychological conditions which are also widely prevalent. Many of the women in this study were not getting better, and had multiple somatic symptoms and other features of depression as measured in the SRQ-20, and as captured in the narratives. We examine their symptoms in toto, understanding that some of the symptoms are psychosomatic (somatic and psychological), and some are somatic and medical. Such is usually the dilemma faced when treating chronic illness in the primary care setting where the first task, when evaluating a patient, is usually to decide what symptoms could be due to undiagnosed medical illness.

The focus of this study is not accurate medical diagnosis. In this paper we examine the symptoms of women screened for depression and then allowed to relate their impressions, unfiltered, of what their problems are. The data we report on is meant to reflect as accurately as possible their symptoms as seen through their eyes and what they think about them. As a result of limits to the methodology employed, some of what is reported on and appears in the tables of this study as symptoms and explanations of mental illness, may, in actuality, be symptoms and explanations of illness that is medical. In practice, some women in the community or in primary care clinics with depression will have serious medical conditions. They have both, and their idioms of distress are a part of the data captured in this study.

## CONCLUSION

Using the cut-off point for "case-ness" of 10 or higher recommended by Scholte et al. (2011), the prevalence of depression ranged from 47.3 % at PHC at MH, to 54.5 % at CNC to 77.6 % at KYB. Demographic data shows that the population of women at KYB is older and living in larger households, and perhaps taking care of more children than the population of women at the other two sites. It is plausible that these factors represent risk factors for depression that contribute, in the KYB population, to a higher prevalence of depression since mental health issues are particularly relevant when women have a multiple stressors in their lives. Analysis of sub-score domains by site suggests that somatic, affective and depressive thoughts do not differentiate as well for depression compared with decreased energy and cognitive impairment. Depressive thoughts, which speak to feelings of hopelessness and uselessness, were not embraced by as many participants diagnosed with depression in this study. This may reflect norms about how psychological, spiritual and moral distress may acceptably be expressed by women in this milieu. For whatever reason, it is possible that most people answered no to the depressive thoughts because that is not how depression manifests itself in this population. The additional items that may have contributed to the diagnosis of depression may have come from the decreased energy and cognitive sub-scales, with women at the KYB center saying yes to more of them. That such high levels of depression were detected in this study from a convenience sample of the community suggests a degree of diagnostic misclassification. It is possible from this study to propose a shortened version of the SRQ-20 emphasizing the cognitive impairment and decrease energy items for screening in this milieu.

Analysis of the interviews indicates that most participants seem to carry with them what

amounts to a personal mythology about their health, as opposed to an informed case history. While these women talk about their illness as somatic, they attribute it to environmental causes and think they will die prematurely as a result. Many of the participant narratives, quoted extensively in this study, seem to mix fact with flights of the imagination. The fear of dying at an early age or of being stricken by some other horrible fate, understandable as it is when, no doubt, such things are occurring all too commonly in the world around them and for reasons that often go unexplained, is a commonly expressed theme about illness impact. In the narratives, links emerge between the women's somatic symptoms and their social circumstances. The somatic idiom may be how women process subclinical levels of distress or social concerns (Kirmayer, Dao & Smith, 1998, p.6), the best available language to signal their predicament and to mobilize support. (Kirmayer, Dao & Smith, 1998, p. 8). In this sense, the somatic idiom may be non-pathological, rather, adaptive.

Most women in this study sought a medical treatment for their, which seemed to hold out to them the promise of a magical cure for their ills. To the detriment of these patients, clinicians who are "unfamiliar with the social meanings "of the somatic idiom "may focus exclusively on the somatic dimensions and so contribute to patients bodily preoccupation" (Kirmayer, Dao & Smith, 1998, p. 6). There are certainly women in this study whose problems are primarily medical. One example, is the young woman with serious urologic problems following a bicycle accident who had been to the hospital in Kampala, and for whom treatment with medicine had failed. She describes herself as having given up and lost all hope. The many more women in our study who report non-specific stomach, heart and chest problems, and talk at the same time, about food insecurity, stress and danger, might be well served by a discussion with their caregiver about how these symptoms and

these social factors are often linked. Other primary care clinic based studies with more of a focus on accurate diagnosis should be performed to focus on the distinguishing features of patients with somatic idiom and major depression, and those with every day somatic idiom that is non-pathological and adaptive. Loss of hope and loss of self –confidence may be distinguishing features.

APPENDIX 1: STUDY INSTRUMENTS

Mental health status was measured by the Self Reporting Questionnaire, 20 items (SRQ 20, WHO 1993; see Table 1),

**Table 1.** Self-Reporting Questionnaire (SRQ 20)

| | Yes | No | Don't know |
|---|---|---|---|
| (1) Do you often have headaches? | | | |
| (2) Is your appetite poor? | | | |
| (3) Do you sleep badly? | | | |
| (4) Are you easily frightened? | | | |
| (5) Do your hands shake? | | | |
| (6) Do you feel nervous, tense or worried? | | | |
| (7) Is your digestion poor? | | | |
| (8) Do you have trouble thinking clearly? | | | |
| (9) Do you feel unhappy? | | | |
| (10) Do you cry more than usual? | | | |
| (11) Do you find it difficult to enjoy your daily activities? | | | |
| (12) Do you find it difficult to make decisions? | | | |
| (13) Is your daily work suffering? | | | |
| (14) Are you unable to play a useful part in life? | | | |
| (15) Have you lost interest in things? | | | |
| (16) Do you feel that you are a worthless person? | | | |
| (17) Has the thought of ending your life been on your mind? | | | |
| (18) Do you feel tired all the time? | | | |
| (19) Do you have uncomfortable feelings in your stomach? | | | |
| (20) Are you easily tired? | | | |

*Source*: WHO (1993).

(16) changed to: 'Do you feel you that have little worth? ' and (17) changed to: 'With all that you have been through, have you thought of ending it all because it is not worth going on? '

## Kleinman's Eight Questions

Study Participant #_____

(1) What do you call your problem? What name does it have?

(2) What do you think has caused your problem?

(3) Why do you think it started when it did?

(4) What does your sickness do to you? How does it work?

(5) How severe is it? Will it have a short or long course?

(6) What do you fear most about your sickness?

(7) What are the chief problems your sickness has caused for you?

(8) What kind of treatment do you think you should receive?

What are the most important results you hope to receive from the treatment?


MAP OF UGANDA

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